PHM – Complex Pharmaceutical Oversight Program (CPOP)

Purpose: To provide oversight of clinically complex and high-cost drugs. The CPOP is a patient-focused and pharmacist-driven program, which uses techniques that are not feasible for a traditional prior authorization program. Iowa Medicaid members receiving complex and high-cost drugs will be proactively identified through pharmacy claims encounter data. Once enrolled in the program, patients will speak directly with a pharmacist about their current medication regimen. The pharmacist will assess medication adherence and administration techniques, adverse events, indications, dosing, duration of therapy, and monitoring parameters. Prescribers may be contacted by a member of the CPOP team to discuss medication-related issues, or to request additional patient records. Evidence-based guidelines and clinical trials will be used to support program interventions. The CPOP supports the prescriber/patient relationship, augments existing care management efforts, and is available free of charge to Iowa Medicaid members.

Identification of Roles:

Pharmacist (RPh) – reviews pharmacy claims; speaks with members about their medications; assesses medication adherence and administration techniques, adverse events, indications, dosing, duration of therapy, and monitoring parameters; communicates with prescribers and pharmacies; generates reports

Pharmacy Technician (PT) – assists RPh with administrative tasks, communicates with prescribers and pharmacies, and generates reports

Medical Director / Associate Medical Director – provides input on targeted drug classes, analyzes the fiscal and clinical outcomes from the program interventions, and provides a written explanation of the findings

Healthcare Data Analyst – provides the weekly high-cost new user report and modifies the report specifications, as needed

Senior Clinical Analyst – generates the quarterly and annual pharmacy / medical / institutional spend reports

Performance Standards: Contractor shall demonstrate annual cost avoidance in the total outlay for complex pharmaceuticals (including an explanation of the Agency-approved methodology for calculating savings). The Pharmacy Medical Services contractor shall provide total cost avoidance as follows:

1. $300,000 in total cost avoidance in SFY 2015
2. $2,000,000 in total cost avoidance in SFY 2016

Path of Business Procedure:

Step 1. Creation of Intervention Work Plans

a. The RPh creates an overall Intervention Work Plan for CPOP. The Medical Director / Associate Medical Director provide input into the drug classes that should be targeted by the program.
b. The Intervention Work Plan includes a high-level description of the intervention, member selection criteria, objectives of the intervention and intended clinical outcomes, protocol for implementing the intervention, reporting methodology, and timeline for monitoring and reporting the intervention. Specific information on targeted drug classes is included, as necessary.

Step 2. Pharmacy Claims Review

a. The PT downloads the weekly high-cost new user report. The RPh determines which members to considering enrolling in the program.
b. Clinically complex and high-cost drugs will be targeted if they meet the Academy of Managed Care Pharmacy (AMCP) definition of a specialty pharmaceutical; and 2) they are so costly that a more intensive, patient-specific evaluation is justified. According to AMCP, a product can be defined as a specialty pharmaceutical if it requires:
    i. A difficult or unusual process of delivery to the patient (preparation, handling, storage, inventory, distribution), Risk Evaluation and Mitigation Strategy (REMS) programs, data collection, or administration), or
    ii. Patient management prior to or following administration (monitoring, disease, or therapeutic support systems)
c. The PT will review a report of pharmacy claims each week on Mondays for the previous week (Sunday – Saturday cycle). The report will identify claims ≥ $5,000 with no activity in same GPI 10 during the previous 6 months. A lower threshold (≥ $3,000) may be used. The RPh will communicate changes to the Healthcare Data Analyst.
d. The RPh performs a thorough review of the selected member's pharmacy claims. The first claims to be examined are the high-cost medication of focus. This includes an assessment of Medication Possession Ratio (MPR), dosage, duration of therapy, drug interactions, duplicate therapy, and previous trials.
e. The RPh reviews related Prior Authorizations (PAs) on file for additional information on the diagnosis, indication, and duration of therapy.
f. The RPh determines if the high-cost medication is being used appropriately based on the information that is available from the member's records, treatment guidelines, and published clinical trials.
g. The RPh reviews pharmacy claims data for high-cost drugs (which includes existing therapy for members) and determines if additional review is needed.
h. The RPh reviews real-time POS claims that reject for 78 – COST EXCEED MAXIMUM for members that do not have a prior authorization in place. The RPh puts an override in place if it is determined that the treatment is appropriate.

Step 3. Prescription Image Requests / Reviews

a. The PT faxes a medical record request to the filling pharmacy requesting an image of the original high-cost prescription. The prescription image is faxed into the Med Management tool for review by the RPh.
b. The RPh reviews the prescribed dose, quantity, and duration of therapy, and compares it to the member's pharmacy claims history to determine if the medication is being administered appropriately.

Step 4. Chart Note Requests / Reviews
a. The PT faxes a medical record request to the prescriber requesting chart notes and laboratory values that pertain to the high-cost medication. The chart notes and laboratory values are faxed into the Med Management tool for review by the RPh.
b. The RPh reviews the chart notes and laboratory values to determine if the high-cost medication is being prescribed appropriately. The RPh uses evidence-based guidelines and clinical trials to determine if the member is meeting their goals of therapy, or if modifications in the treatment regimen are needed.
c. If additional information is needed after reviewing the member's pharmacy claims history, prescription image, chart notes, and laboratory values, the RPh may contact the prescriber by telephone to gather additional information or discuss medication-related issues.

Step 5. Member Communication
a. The RPh will contact a new member by telephone after the claim for the high-cost medication appears on their POS profile. Topics to be discussed include the dosing, storage requirements, adverse events, and special administration techniques.
b. The RPh or PT will contact a member by telephone if there are unexplained gaps in medication refills. Reasons for the gaps in refills will be assessed, and the RPh will provide additional education on the medication accordingly.
c. The RPh will contact a member by telephone at various intervals during their course of therapy to conduct ongoing assessments.

Step 6. Use of the Med Management Tool
a. The RPh enters clinical information pertaining to the member into the Med Management Tool and assigns a follow-up date.
b. The RPh faxes a letter to the prescriber using the Med Management Tool. This letter informs the prescriber that the member was enrolled in the program.

Step 7. Reporting
a. The RPh submits a request to the Senior Clinical Analyst to generate the quarterly and annual pharmacy / medical / institutional spend reports.
b. The RPh uses the Med Management Tool to export fiscal and clinical data for the quarterly and annual reports.
c. The Medical Director / Associate Medical Director analyze the fiscal and clinical outcomes from the program interventions, and provide a written explanation of the findings.

d. The RPh compiles the information from the Senior Clinical Analyst, the Med Management tool, and the Medical Director / Associate Medical Director. The RPh submits the quarterly and annual reports to the Department. Quarterly reports are due 15 business days following the end of the quarter and annual reports are due 30 business days following the end of the state fiscal year. Medical claims reporting shall begin six months after program initiation due to claims lag.

Forms/Reports:

1. CPOP Enrollment Letter (Form 470-5304)
2. CPOP Record Request Letter (Form 470-5305)
3. Quarterly CPOP Report
4. Annual CPOP Report

RFP References: 6.3.5., 6.3.5.2.a., 6.3.5.2.b., 6.3.5.2.c., 6.3.5.2.d., 6.3.5.2.e., 6.3.5.2.f., 6.3.5.3.a.

Interfaces: Med Management Tool

Attachments: None